The new health checks must not be allowed to increase inequalities

From April 2009–2010, the NHS is being asked to implement a risk assessment and management programme for people in England aged 40–74, to identify those at risk of developing vascular disease. One vital question, however, is whether such a programme will actually increase – rather than reduce – health inequalities.

The Department of Health has asked PCTs to work through the service provision, workforce and prescribing implications of introducing vascular checks before taking decisions about the rate at which they plan to roll out the programme.

It is estimated that the screening programme could prevent at least 9,500 heart attacks and strokes a year (of which 2,000 would be fatal), prevent at least 4,000 people a year from developing diabetes and enable earlier detection of at least 25,000 cases of diabetes or kidney disease (Department of Health, 2008a).

Of the options considered, the preference was for starting screening at the age of 40, with checks every five years. The average cost for a basic vascular check is estimated at £23.70 (DH, 2008b). There are also the costs of knock-on tests if a patient has high blood pressure, is diagnosed with diabetes or has high fasting blood glucose. The DH has developed a toolkit, which enables PCTs to use local prevalence rates to estimate local demand for interventions following the checks. This will require extra capacity to deliver smoking cessation support and an increase in obesity interventions.

For an average GP practice of three GPs, it is estimated this is equivalent to 330 new invitations and 250 new attendances per year for screening, of which 125 will be additional work. However, while detailed national modelling has been carried out, the proportion of people found to be at high vascular risk is likely to vary greatly at local level, and will be high in deprived areas and among black and minority ethnic patients. It would be useful for PCTs to have an estimate of the proportion of the population with a greater than 20% cardiovascular disease risk, and the costs involved, with a facility to provide such estimates at practice level.

A campaign to raise public awareness should be carried out before the programme is launched. For example, this could be done by leaflet drops. Personalised GP-signed mailed invitations could be used as a recruitment method, but a fairly low uptake of 30–40% should be expected, and arrangements for a follow-up letter and telephone call should be put in place. Opportunistic screening of patients over 75 should be considered – the vascular checks programme has a cut-off at 74, and most strokes occur after 75. To prevent stroke, it is important to ensure hypertension is controlled in this age group.

Extra funding and staff should be allocated to reduce socioeconomic and ethnic variations in uptake.

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GLADYS XAVIER is deputy director of public health, NHS Redbridge

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